UAB MEDICINE
PRIMARY CARE

THE KIRKLIN CLINIC OF UAB HOSPITAL / AFFILIATED CLINICS

UAB Health Centers • Prime Care • Your Health Review

Welcome to the Kirklin Clinic of UAB Hospital! Each of us has a unique medical history. Your history will help to diagnose and treat your problems. We can review this in the examining room when we discuss the reasons for your visit. Because this information is important, please place a (*) beside any questions you don't understand.

Patient Name: _____

Date of Birth: _____

Date of Service: _____

Physician: _____

Medical Record Number: _____

CURRENT INFORMATION

Today's date: _____

Your Name: _____ Date of Birth: _____

Name you prefer to be called: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Day: _____ Cell: _____

Preferred Contact Phone: _____

☐ Male ☐ Female Social Security #: _____ - _____ - _____ Last grade finished: _____

☐ Single ☐ Married - when? _____ ☐ Divorced - when? _____ ☐ Widowed - when? _____

Occupation: _____ ☐ Retired - when? _____

Hobbies/Interests: _____

Religious Denomination (optional): _____

Person to contact in an emergency: _____

Relationship to you: _____ Phone: _____

Pharmacy you normally use: _____ Phone: _____

Previous physicians you have seen: _____

Last complete exam: _____ Physician: _____

Were you referred to our clinic? ☐ Y ☐ N If so, by whom? _____

Insurance Plan: _____ Policy number: _____

Policy holder: _____ Group number: _____

Second Insurance Plan: _____ Policy number: _____

Policy holder: _____ Group number: _____

Reason for your visit today - Please indicate your major concern or concerns:

_____

_____

Please list any SERIOUS ILLNESSES you have had in the past or have now:

(high blood pressure, diabetes, heart problems, stroke, kidney problems, cancer, liver problems, etc.)

Year of Onset	Illness	Condition at present

Please list all SURGICAL PROCEDURES (operations) that you have had:

(appendectomy, hysterectomy, gallbladder, tonsillectomy, heart surgery, cataract surgery, etc.)

Year	Surgical Procedure	Reason	Surgeon

MEDICATIONS YOU ARE CURRENTLY TAKING:

(prescription medications, over-the-counter medications, and herbal or dietary supplements)

Medication	Dose	Taken how often?	Medication	Dose	Taken how often?

MEDICATION ALLERGIES List medications that you are allergic to and type of reaction you had:

_____

_____

_____

PERSONAL HEALTH HABITS/LIFESTYLE

Exposure: Check any of the following to which you have *frequently* been exposed:

☐ chemicals ☐ cleaning fluids ☐ oils ☐ fumes ☐ smoke ☐ continuous loud noise

☐ coal dust ☐ cement ☐ asbestos ☐ x-rays ☐ radioactive materials

Alcohol: ☐ Non-drinker ☐ Drink only rarely ☐ Drink socially ☐ Drink some each day

If you drink: Have you ever felt the need to cut down on drinking? ☐ Y ☐ N

Have you ever felt annoyed by criticism of your drinking? ☐ Y ☐ N

Have you ever had guilty feelings about drinking? ☐ Y ☐ N

Have you ever had an eye-opener (a drink first thing in the morning)? ☐ Y ☐ N

Tobacco: ☐ Never a smoker

☐ Current smoker – Number of packs a day:_____ Age you began smoking:_____

☐ Quit smoking – How many years did you smoke:_____ Year that you quit:_____

☐ Chew tobacco or dip snuff

Caffeine: ☐ Coffee drinker – cups/day:_____ ☐ Tea/caffeine-containing sodas – cups or glasses/day:_____

Safety: ☐ Do you wear seat belts in a car? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never

☐ Have you ever been a victim of physical abuse? ☐ Y ☐ N

Exercise: ☐ No regular exercise ☐ Regular exercise – type of exercise: _____

PREVENTIVE HEALTH TESTS

(list year, location, result of most recent tests)

Chest X-ray _____

EKC_____

Mammogram _____

Pap smear_____

Cholesterol _____

Colon exam_____

Prostate exam _____

Bone Density (DEXA) _____

IMMUNIZATIONS

(Check the ones you have had)	Year, if known
Tetanus shot	
Flu shot	
Pneumovax (pneumonia shot)	
Hepatitis B vaccination (3 shots)	
TB skin test	
Have you ever had rubella (German measles)? ☐ Y ☐ N	
Have you had rubella vaccine? ☐ Y ☐ N	
Have you had measles? ☐ Y ☐ N	
Measles vaccine? ☐ Y ☐ N	

UAB MEDICINE
PRIMARY CARE

Your Name: _____ Mecical Record Number:_____

HEALTH OF YOUR FAMILY

	Good	Poor	Died	For each family member, please note his/her age and any major health problems (diabetes, cancer, high blood pressure, etc.) If deceased, note age and cause of death.
Father (natural, biological)	☐	☐	☐	_____
Mother (natural, biological)	☐	☐	☐	_____
Brothers/Sisters:				
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
Spouse:_____	☐	☐	☐	_____
Children:_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____

Please note any major diseases in your other close blood relatives (grandparents, aunts/uncles):

_____

_____

REVIEW OF SYSTEMS Please mark with a check (✔) if you **currently** have problems with. If item is not checked your response is considered negative.

General:

☐ Sleeplessness ☐ Fatigue ☐ Fevers ☐ Weight gain ☐ Loss of appetite
☐ Excessive sleep ☐ Passing out ☐ Night sweats ☐ Weight loss

Skin:

☐ Rash ☐ Dryness ☐ Itching ☐ Lumps/warts or mole changes
☐ Bruises ☐ Nail problems ☐ Hair problems ☐ Varicose veins

Head-Eyes-Ears-Nose-Throat:

☐ Wear glasses ☐ Hearing loss ☐ Dental/gum problems ☐ Headaches
☐ Wear contacts ☐ Wear hearing aid ☐ TMJ syndrome ☐ Dizziness
☐ Double vision ☐ Ringing of ears ☐ Wear dentures ☐ Sinus disorder
☐ Cataracts ☐ Ear infection ☐ Nasal drip ☐ Hoarseness
☐ Glaucoma ☐ Ears clogged ☐ Nasal polyps

Blood:

☐ Anemia ☐ Difficulty clotting ☐ Easy bruising ☐ Sickle cell ☐ Thalassemia
☐ Other: _____

Nodes and glands:

☐ Swollen/painful glands ☐ Excessive thirst ☐ Heat intolerance ☐ Overactive thyroid
☐ Diabetes ☐ Excessive urination ☐ Cold intolerance ☐ Underactive thyroid

Breasts:

☐ Lumps ☐ Deformity ☐ Pain prior to menstruation ☐ Cysts ☐ Nipple discharge
☐ Other: _____

Lungs:

☐ Asthma ☐ Emphysema ☐ Bronchitis ☐ Shortness of breath
☐ Pneumonia ☐ Pleurisy ☐ Chronic cough ☐ Shortness of breath-with exercise
☐ TB ☐ Hyperventilation ☐ Coughing blood ☐ Shortness of breath-lying down

Cardiovascular:

☐ Heart attack ☐ Heart surgery ☐ Rheumatic fever
☐ Chest discomfort at rest ☐ High blood pressure ☐ Heart murmur
☐ Chest discomfort with exertion ☐ Irregular pulse (skipped beat) ☐ Heart valve problem
☐ Angina pectoris ☐ Leg pain with walking ☐ Swelling ankles
☐ Phlebitis or blood clot ☐ Other:_____

Have you ever had an exercise test (cardiac stress test)? ☐ Y ☐ N Year and result:_____

Gastrointestinal:

☐ Difficulty swallowing ☐ Heartburn ☐ Blood in stool
☐ Hiatal hernia ☐ Colitis ☐ Hemorrhoids
☐ Abdominal pain ☐ Diarrhea ☐ Gall bladder disease
☐ Ulcer ☐ Hernia ☐ Hepatitis
☐ Constipation – Do you take anything for constipation?_____

Genito-Urinary:

☐ Kidney/bladder infection ☐ Loss of bladder control (incontinence) ☐ Blood in urine
☐ Pain or burning with urination ☐ Increased frequency of urination ☐ Kidney Stone
☐ Awakening at night to urinate ☐ Other:_____

Men:

☐ Difficulty starting to urinate ☐ Discharge from penis
☐ Difficulty urinating steady streams ☐ Dribbling after urination
☐ Feeling of incomplete bladder emptying ☐ Prostate condition
☐ Venereal or sexually transmitted disease ☐ Loss of sex drive
☐ Difficulty getting an erection ☐ Other: _____

Women:

Age at first period:_____ Date last normal menstrual period began:_____

Periods: ☐ Regular – Average frequency: every_____days ☐ Irregular – lasting_____days
☐ Spotting between periods ☐ Heavy periods ☐ Passage of clots

Do you use any type of birth control? ☐ Y ☐ N What type? _____

Have you gone through menopause? ☐ Y ☐ N Age at menopause _____

☐ Hysterectomy – when?_____ ☐ Hormone treatment after hysterectomy or menopause
☐ Abnormal bleeding from vagina ☐ Pelvic inflammatory disease
☐ Yeast infections ☐ Venereal or sexually transmitted disease
☐ Pain with sexual intercourse ☐ Loss of sex drive/other sexual difficulties

Number of pregnancies:_____ Number of live birth:_____ Number of miscarriages/abortions:_____

☐ Other:_____

Musculoskeletal:

☐ Arthritis ☐ Muscle weakness ☐ Difficulty walking
☐ Gout ☐ Broken bones – which? _____

Neurological:

☐ Seizures (epilepsy) ☐ Memory loss ☐ Depression ☐ Loss of coordination
☐ Numbness ☐ Loss of balance ☐ Anxiety

Patient Signature: _____ Date:_____

Thank you for taking the time to fill out this medical history!
Please return this form as soon as possible or bring it with you on your next planned visit.

Physician Signature: _____ Date:_____